respectively. PAL beyond day 7 occurred in 4 patients (8.9%). Of these, one subsided on day 11 and 3 patients were discharged with flutter valves, with resolution of air leak within 3 weeks. Re-intervention was not required in any patients. Significantly more PALs ($p<0.05$) were seen in recent smokers and those undergoing urgent surgery.
Conclusion: Air leak following pneumothorax surgery is common but mostly resolved spontaneously. Persistance for over 7 days was only seen in 9% of patients. Recent smokers and urgent patients appear at a greater risk. Consideration should be given to strategies to minimise PALs.

CHARACTERISTICS OF BREAST CANCER AT THE EXTREMES OF AGE

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Background: Increasing age at diagnosis of breast cancer has been associated with a shift in tumour biology. We performed an analysis limited to the extremes of age so as to clarify the associations of age with features of disease.
Method: We reviewed all new presentations of breast cancer in a single centre between 1998 and 2005. Patients aged 40 and under and 75 and over were included in a statistical analysis of disease characteristics, progression, recurrence and mortality.
Results: The younger and older groups contained 69 and 255 cases, respectively. Mean follow-up was 6.4 years. The younger patients had significantly more high-grade tumours (50.7% vs 26.6%, $p<0.001$) and tended towards more lymphovascular invasion and node-positive disease. Following surgery, the recurrence rate was significantly higher in the young (29.4% vs 17.1%, $p = 0.03$). In the elderly, delayed presentation was associated with larger tumours (34.9 vs 25.0mm, $p = 0.01$) and higher overall mortality (54% vs 37%, $p = 0.001$).
Discussion: The current data support breast cancer in the young as a more aggressive disease entity, requiring more aggressive treatment. Disease in the elderly appears more favourable, but effective management requires prompt detection and treatment.

BRIEFING AND DEBRIEFING IN THE CARDIAC OPERATING ROOM. ANALYSIS OF IMPACT ON THEATRE TEAM ATTITUDE AND PATIENT SAFETY

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Background: Error in health services delivery has long been recognised as significant cause of inpatient morbidity and mortality. Root-cause analyses have cited communication failure as one of the contributing factors in adverse events. The formalised fighter pilot mission brief and debrief formed the basis of the National Aeronautics and Space Administration (NASA) crew resource management (CRM) concept produced in 1979.
Methods: This is a qualitative analysis of our experience with the briefing-debriefing process applied to cardiac theatres. We instituted a policy of formal operating room (OR) briefing and debriefing in all cardiac theatre sessions.
Results: The first 118 cases were reviewed. A trouble-free operation was noted in only 28 (23.7%) cases. We experienced multiple problems in 38 (32.2%) cases. A gap was identified in the second order problem solving in relation to instrument repair and maintenance. Theatre team members were interviewed and their comments were subjected to qualitative analysis. The collaborative feeling is that communication has improved.
Conclusion: The health industry may benefit from embracing the briefing-debriefing technique as an adjunct to continuous improvement through reflective learning, deliberate practice and immediate feedback. This may be the initial step toward a substantive and sustainable organizational transformation.

NEOADJUVANT CHEMOTHERAPY IN BREAST CANCER DOES NOT AFFECT SURGICAL YIELD OF AXILLARY LYMPH NODES

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Introduction: Chemotherapy can lead to downsizing of axillary lymph nodes metastases. Many surgeons believe that node count after axillary clearance in breast cancer patients who have had neoadjuvant chemotherapy may be lower than those having primary surgery.
Method: The Portsmouth breast unit database was used to identify a group of 59 consecutive women who underwent surgery including axillary clearance following neoadjuvant chemotherapy for breast cancer over a 5 year period. This group was compared to a group of 64 consecutive patients over the same period that had primary surgery including axillary clearance. Women undergoing sentinel node biopsy were excluded from the study. The number of lymph nodes reported in each group was compared.
Results: The median number of nodes removed at axillary clearance was 11 (Range 2-30) in the neoadjuvant chemotherapy group, compared to 12 (Range 1–25) in the primary surgery group (Mann-Whitney U test, $p = 0.0643$). Although the neoadjuvant chemotherapy group were more likely to have fewer than 10 nodes removed (32.2% in the neoadjuvant chemotherapy group, compared to 25.4% in the primary surgery group), this did not reach statistical significance (Fisher's test, $p = 0.4298$).
Conclusion: Neoadjuvant chemotherapy for breast cancer does not alter the yield of lymph nodes in axillary clearance.

LAPAROSTOMY IN THE TREATMENT OF ABDOMINAL EMERGENCIES

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Aims: Mortality rates following emergency laparotomy are high. This study aims to assess the use of laparostomy in a district-general-hospital setting.
Methods: Retrospective case review of patients admitted to the Adult Intensive-Care-Unit(ICU) following emergency laparotomy with laparostomy formation during January 2007-March 2009.
Results: During the 27-month study period, 72 patients(26 female, median age 65, range 21-86) underwent emergency laparotomy and formation of laparostomy. Forty-one patients had faecal peritonitis secondary to colonic perforation(27 patients) or anastomotic leaks(14 patients). The aetiology in the remaining 31 patients was bowel obstruction(7), ischaemic or inflammatory bowel(6), severe pancreatitis(5), upper GI perforation(4), advanced pelvic malignancy treated by exenteration(3), volvulus[2], trauma[1], or others(3). Fifty-three patients(74%) had their laparostomy at initial emergency laparotomy. Eighteen percent underwent a laparostomy following re-look laparotomy within 72 hours. Twenty-three patients(32%) died. Thirty of 49 patients who survived(61%) had their laparostomy closed, 29 of them prior to discharge from ICU(mean 3 days, range 1-7). One patient had his laparostomy closed electively after 20 months. Four patients had split-skin grafts to facilitate closure. Median

length of stay for patients discharged from ICU was 33 days(range 8-767 days). Closure of laparostomy was inversely related to death($p = 0.001$), but death did not significantly correlate with faecal peritonitis.

THE NUMBER OF INSTABILITY MARKERS IS A SIGNIFICANT PREDICTOR OF OUTCOME IN DISTAL RADIAL FRACTURES AND CAN BE USED AS A GUIDE TO DEVISE A STANDARDISED MANAGEMENT STRATEGY FOR THESE FRACTURES

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Background: Distal radial fractures are extremely common. An effective treatment strategy ensures good outcome and resource usage.
Aim: To identify the significance of the number of instability markers in distal radial fractures in predicting outcome and proposing a standardised management strategy.
Methods: Data was collected retrospectively over three months. Relevant instability markers identified through a literature review were: age >60, dorsal angulation >20°, intra-articular fracture, ulna fracture, dorsal comminution, radial shortening and osteoporosis. Each patient had number of instability markers, management and outcome recorded. Outcomes were graded as "good" or "poor" based on complications, function achieved and length of follow-up required.
Results: 119/207 patients had = 3 instability markers (Group A) and 88/207 had = 4 (Group B). In Group A, 91% achieved "good" outcome regardless of treatment type, versus 66% in Group B ($p<0.001$). In Group B, amongst patients who had surgery (29), 79% achieved "good" outcome, however those with manipulation alone (38), only 58% achieved "good" outcome ($p = 0.03$).
Conclusion: = 4 instability markers give a poorer outcome. Patients with = 4 markers did better with surgery than manipulation alone. However, non-operative management yields equally good results in patients with = 3 markers. This is a pilot study for future primary research.

HETEROGENEITY IN RANDOMISED CLINICAL TRIALS OF ENDOVENOUS INTERVENTIONS FOR VARICOSE VEINS

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Aims: Efficacy of endovenous treatments for venous reflux has been demonstrated in numerous randomised clinical trials, although significant heterogeneity may exist between studies. We aimed to evaluate and compare outcome measures and reporting of randomised trials investigating varicose vein interventions.
Methods: Pubmed, Cochrane and Google Scholar databases were systematically searched. Randomised clinical trials published between January 1966 and June 2009 evaluating endovenous interventions for varicose veins were included. Published study reports were evaluated against the 2007 American Venous Forum recommended reporting standards.
Results: Twenty-eight randomised trials fulfilled inclusion criteria. Median patient age (reported in 20/28 studies) ranged from 33-54 years. 31 different outcome measures were utilised including 13 different questionnaires, varicose vein recurrence at 38 time points and 30 categories of complications. Duplex ultrasonography was used in 21/28 trials to assess recurrence. Quality of life was only evaluated in 11 studies and follow-up periods ranged from 3 weeks to 10 years.
Conclusions: Meaningful comparison across randomised studies of endovenous treatments is made difficult by considerable variations in study populations and outcome measures between trials. This highlights the need for the use of prospectively agreed population selection, and reporting standards for outcome measures in randomised clinical assessments of new treatments.

TEMPORAL LOBE ABSCESSES AND THE ROLE OF ENT: A 10-YEAR REVIEW

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Background: Temporal lobe abscess carries a 10% mortality and up to 50% of patients suffer persistent seizures. Management lacks consistency, with only isolated case reports available. Chronic otitis media and mastoiditis are recognised risk factors but the value of adjuvant ENT surgery remains unknown.
Objectives: To determine the role of peri-operative mastoid drainage or mastoidectomy in reducing neurosurgical re-operative rates and outcome.
Methods: A single centre, retrospective audit from 1999-2009. Microbiologically proven temporal lobe abscesses that underwent neurosurgery were included. Data collected included neurosurgical procedure, radiological findings pre- and post-operatively, organism(s) isolated, ENT procedure and timing, neurosurgical re-operation rate and outcome.
Results: 26 patients were identified that met our inclusion criteria. All patients had antibiotic therapy. Radiological evidence of middle ear or mastoid involvement was reported prior to surgery in most patients. Some patients underwent ENT procedures. A number of patients underwent repeat neurosurgery. Statistical significance was determined using Chi-square testing. Preliminary results show patients that underwent adjuvant ENT surgery had lower re-operation rates and better outcomes.
Conclusions: This review will be the first audit to determine the role of adjuvant ENT surgery in the management of temporal lobe abscesses with co-existing middle ear or mastoid infection.

PSYCHIATRIC SERVICES TO THE PLASTIC SURGERY UNIT ARE NOT AN EPITOME

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Introduction: Plastic surgery trauma units (PSTUs) will be involved in many cases that need joint psychiatric care. There isn't a standard framework in place for joint plastic and psychiatric services. We aim to assess the satisfaction of the psychiatric services on the PSTU across the UK.
Methods: PSTUs in the UK were identified using BAPRAS website. Each unit was enquired relating to the psychiatric input to the patients care. The unit satisfaction with the services were noted and the whether there was specific funding in place for joint services.
Results: PSTUs ($n = 62$) were identified. None of the psychiatry services assessed or had seen the patients pre-operatively. 10% of units admitted that patients were not seen post-operatively. Units would have to wait a mean of two days before a mental health assessment was made. 80% of units didn't have funding available for joint care to take place.